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Issue Date: 13 October 2005

In the Matter of:
FREDDIE R. JORDAN
Claimant

Case No.: 2004 BLA 6829

v.

MILL BRANCH COAL CORP./
AMERICAN MINING INSURANCE CO.
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:
Mr. Joseph E. Wolfe, Attorney
For the Claimant

Ms. Tracy A. Berry, Attorney
Ms. Anne Musgrove, Attorney
For the Employer

Before:
Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Freddie R. Jordan for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

On July 17, 2003, Mr. Jordan filed his claim for black lung disability benefits (DX 2).[1] On January 14, 2004, a claims examiner issued a notice indicating that Mr. Jordan would be entitled to benefits if a decision was issued at that time; however, the parties were provided an

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

opportunity to file additional evidence (DX 36). After a review of additional evidence, the District Director issued a proposed decision and order denying benefits to Mr. Jordan (DX 43). On June 28, 2004, the claimant appealed the adverse decision and requested a hearing (DX 47). The case was then forwarded to the Office of Administrative Law Judges on September 21, 2004 (DX 53). Pursuant to a Notice of Hearing, dated November 29, 2004 (ALJ 1), I conducted a hearing in Abingdon, Virginia on March 26, 2005, with Mr. Jordan, Mr. Wolfe, Ms. Berry and Ms. Musgrove.

Evidentiary Discussion

At the hearing and during my adjudication of this claim two evidentiary issues developed involving rebuttal chest x-ray evidence and consideration of chest x-ray interpretations not contained in the record.

Rebuttal Chest X-Ray Evidence

Under the regulatory evidentiary restrictions applicable to this claim under 20 C.F.R. § 725.414, each party is entitled to offer into evidence two chest x-rays interpretation as part of the case-in-chief. Each party may also offer one interpretation as rebuttal to the other parties case-in-chief chest x-ray study and the chest x-ray developed as part of the U.S. Department of Labor ("DOL")-sponsored pulmonary examination.

At the hearing, the Claimant offered Dr. Alexander's interpretation of the October 23, 2003 chest x-ray (CX 3 and also included in DX 19) as rebuttal to Dr. Patel's interpretation of the film as part of the DOL-sponsored pulmonary examination. Employer objected to the admission of CX 3 because Dr. Alexander's positive interpretation did not represent rebuttal of Dr. Patel's positive interpretation of the same study. The Claimant responded that since Dr. Alexander reported a different profusion level than Dr. Patel, his interpretation was rebuttal and should be admitted. I deferred a decision on the admissibility of Dr. Alexander's interpretation, CX 3,[2] based on the possibility the appellate bodies might later provide guidance on what constitutes rebuttal under the evidentiary limitations.

Since the hearing, contrary to my intentions, the appellate authorities have been silent on the issue. As a result, I am confronted with the definitional dispute on whether "rebuttal" means different or opposite. In absence of any further guidance, I conclude that the rebuttal provisions of 20 C.F.R. §§ 725.414 (a) (2) (ii) and (3) (ii) concern evidence offered to refute case-in-chief evidence. In my opinion, rebuttal in this case means opposite or contrary, rather than different. Although Dr. Alexander disagrees with Dr. Patel on the extent of the opacities' profusion, he believes the October 23, 2003 film is positive for pneumoconiosis. His positive interpretation does not refute Dr. Patel's positive for pneumoconiosis interpretation for the same film. Consequently, Dr. Alexander's interpretation does not represent rebuttal of Dr. Patel's findings.[3] As a result, Dr. Alexander's interpretation of the October 23, 2003 chest x-ray is not

[2]At one point of the hearing, I misspoke and indicated that CX 3 was admitted (TR 24).

[3]For its case-in-chief, the Claimant submitted two positive interpretations by Dr. DePonte of an x-ray taken September 1, 2003 (CX 1) and Dr. Patel of an x-ray taken April 19, 2004. As a result, Dr. Alexander's positive

admissible as rebuttal evidence under 20 C.F.R. § 725.414 (a) (2) (ii). CX 3 will be marked, "offered not admitted." And, the portion of DX 19 containing this interpretation is also not admitted.

Consideration of Chest X-Rays Not in Evidence

According to 20 C.F.R. § 725.414 (a) (3) (i), each item of medical evidence contained in a medical report must also be admissible under 20 C.F.R. § 725.414. In his medical report (EX 1), Dr. Castle considered a couple of chest x-ray interpretations from 2000 that were not admitted into the record because they would have exceeded the regulatory evidentiary restrictions. However, I have not excluded Dr. Castle's medical report for three reasons. First, Dr. Castle clearly separated his pulmonary examination from his medical record review. As a result, I have no evidentiary limitation concern in regards to his examination-based conclusions. Second, several portions of his analysis in regards to the presence of complicated pneumoconiosis and the nature and extent of Mr. Jordan's pulmonary impairment were principally based on admitted radiographic interpretations and pulmonary test results. Third, at the hearing, Claimant's counsel did not object to the admission of Dr. Castle's opinion, EX 1.

Summary

In light of the above determination and since the Employer withdrew two exhibits previously tendered, specifically EX 3 and EX 4 (TR 25-26), my decision in this case is based on the hearing testimony and the following exhibits: DX 1 to DX 55[4]; CX 1 and CX 3; and EX 1, EX 2 and EX 5.

ISSUES

1. Whether Mr. Jordan has pneumoconiosis.

2. If Mr. Jordan has pneumoconiosis, whether his disease arose out of coal mine employment.

3. Whether Mr. Jordan has a totally disabling respiratory impairment.

4. If Mr. Jordan is totally disabled, whether his total disability is due to coal workers' pneumoconiosis.

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interpretation of the October 23, 2003 film may not come in as part of the case-in-chief since it would exceed the two chest x-ray interpretation restriction in 20 C.FR. § 725.414 (a) (2) (i).

[4]Due to the evidentiary restrictions, Dr. Abrahams' interpretation of a September 7, 2000 chest x-ray in DX 15 and Dr. Scott's interpretation of October 23, 2003 chest x-ray in DX 20 were not admitted (TR 26 and 30).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Jordan's length of coal mine employment was at least 28 years; b) Mill Branch Coal Company is the responsible operator in this case; and c) Mrs. Karen Jordan is an eligible spouse for the purpose of augmenting any benefits that may be payable under the Act (TR 8-10 and 47).[5]

Preliminary Findings

Born on April 2, 1953, Mr. Jordan married Mrs. Karen Hale (Jordan) on February 1, 1974 (DX 2 and DX 12). Mr. and Mrs. Jordan live together in Coeburn, Virginia. Mr. Jordan worked in coal mine employment for 28 years. In his last job, he was a "primer," where he "primed the top of the mine." In this job, he worked at the face of the mine "where the dust was the worst," according to his reports and testimony. At this job, Mr. Jordan would be required to stand and crawl all day and lift anywhere from 50 to 100 pounds on various occasions. Prior to his job as a "primer," Mr. Jordan was a roof bolter for 25 years. He left mining when he ruptured a disc in his back while lifting a "seal block" on the job. He had surgery in 2003 to repair the disc, but has not returned to any type of work since this back surgery (DX 2; DX 4; DX 9; TR 34-38; and, TR 40-44).

Mr. Jordan also has breathing problems and shortness of breath, which began when he still worked in mining (TR 35). Claimant stated that he smoked cigarettes from about age 16 to about age 50 and quit several times throughout this period (TR 42). He stopped smoking in August of 2003, but he estimated that he smoked for a total of about 10 years over the years at an average rate of about one pack of cigarettes per day (TR 42).

Entitlement to Benefits

To receive benefits under the Act, a claimant must prove by a preponderance of the evidence several facts. First, the coal miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[8] Otherwise, the claimant must provide competent evidence to establish

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[5]The question was also raised at the hearing about whether Mr. Jordan had a disabled son as described on his application for benefits (DX 2). However, Claimant's attorney explained at the hearing that this child was 29, no longer living at home and not dependent on Claimant (TR 9-10).

[6]20 C.F.R. § 718.202.

[7]20 C.F.R. §718.203 (a).

[8]20 C.F.R. §718.203 (b).

the relationship between pneumoconiosis and coal mine employment.[9] Third, the coal miner must demonstrate total disability.[10] Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.[11]

Issue # 1 - Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[12] The regulatory definitions include both clinical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[13] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[14] and medical opinion (§ 718.202 (a)(4)). Mr. Jordan has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Jordan will have to rely on chest x-rays, regulatory presumption of complicated pneumoconiosis, or medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Compton*,[15] I must consider all the medical evidence together to determine whether a claimant can establish pneumoconiosis.

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[9]20 C.F.R. §718.203 (c).

[10]20 C.F.R. §718.204 (a).

[11]*Id.*.

[12]20 C.F.R. § 718.201 (a).

[13]20 C.F.R. § 718.201 (a) (1) and (2).

[14]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[15]*See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). Because Claimant last worked as a coal miner in Virginia, the law as interpreted by the United States Court of Appeals for the Fourth Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
September 1, 2003	DX 17 and CX 1	Dr. DePonte B,[16] BCR	Positive for pneumoconiosis, profusion category 1/1,[17] type s opacities.[18] Category A large opacity consistent with pneumoconiosis present; could also be carcinoma.
(same)	DX 15	Dr. Abrahams, B	Negative for pneumoconiosis. Faint nodular patchy infiltrate present in right upper lobe, unknown etiology.
October 23, 2003	DX 14	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion category 1/1; type s/t opacities. No large opacity consistent with pneumoconiosis present. Nodule, 0.8 centimeters, present in right upper lung zone; may be granuloma or developing neoplasm.
(same)	EX 5	Dr. Scatarige, B, BCR	Negative for pneumoconiosis. A "few small speculated nodular opacities" in the right upper lung, "up to 1 cm in diameter." Probably "scarring."
February 19, 2004	DX 15	Dr. Halbert, B, BCR	Negative for pneumoconiosis and large opacity consistent with pneumoconiosis. Nodular-appearing infiltrate in right upper lobe.
April 19, 2004	CX 2	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion category 1/1; type p/t opacities. Category A large opacity, "indeterminate" of either complicated pneumoconiosis or malignancy. Located in the right upper lung zone, the opacity is a "poorly detailed, speculated, non-calcified mass up to 2 centimeters in diameter"
(same)	EX 2	Dr. Scatarige, B, BCR	Negative for pneumoconiosis. A 1.5 x 2 centimeter focal mass/fibrosis is located in the right upper lung, representative of mild infiltrate, scarring or mass.

[16]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[17]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[18]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

August 11, 2004	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. A "few small nodules" in right upper lung "compatible with granulomata rather than metastases."

Of the five chest x-rays in the record, no dispute exists concerning two of the films. Dr. Halbert, a dually qualified radiologist, found the February 19, 2004 film to be negative. Similarly, Dr. Wheeler determined the August 11, 2004 chest x-ray was negative for pneumoconiosis. Based on these two undisputed interpretations, I find that the chests x-rays from February 19, 2004 and August 11, 2004 are negative for the presence of simple pneumoconiosis.

The physicians who evaluated the remaining three radiographic studies reached conflicting conclusions. First, in the September 1, 2003 x-ray, Dr. DePonte, a dual qualified radiologist, found the presence of pneumoconiosis. Dr. Abrahams, a B-reader, disagreed and considered the study to be negative for pneumoconiosis. Because DePonte is a more highly qualified reader, I assign greater probative weight to her interpretation and find the September 1, 2003 x-ray is positive for the existence of pneumoconiosis.[19]

Next, in the October 23, 2003 x-ray, Dr. Patel, a dual qualified radiologist, found the presence of pneumoconiosis. Dr. Scatarige, also a dual qualified radiologist, did not. Because these physicians are equally well qualified to interpret x-rays films for pneumoconiosis, I find this radiological study inconclusive on the presence of the disease.

Third, concerning the April 19, 2004 chest x-ray, Dr. Patel and Dr. Scatarige again reached another medical standoff. Dr. Patel found the existence of pneumoconiosis while Dr. Scatarige did not. Since these two physicians are equally qualified, I find the April 29, 2004 x-ray inconclusive, as well, in determining the presence of pneumoconiosis.

In summary, one of the films is positive for the presence of pneumoconiosis (September 1, 2003); two are negative for the presence of pneumoconiosis (February 19, 2004 and August 11, 2004); and two are inconclusive (October 23, 2003 and April 19, 2004). As a result, the preponderance of the probative radiographic evidence in this case is negative and does not support a finding of pneumoconiosis under the provisions of 20 C.F.R. § 718.202 (a) (1).

Regulatory Presumption – Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of death due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner suffered from a chronic dust disease of the lung which "when diagnosed by chest X-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C," there shall be an irrebuttable presumption that his death was due to

[19]The courts and Benefits Review Board have determined that it is proper to give probative weight to the interpretation of a dual qualified radiologist in comparison to a physician who is only a B reader. *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co*., 22 B.L.R. 1-1 (1999) (en banc on recon.) and *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128 (1984).

pneumoconiosis.[20] This type of large opacity is called "complicated pneumoconiosis." The statute and regulation, 30 U.S.C. 921 (c) (3) (B) and (C) and 20 C.F.R. §§ 718.304 (b) and (c), also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by "congressionally defined criteria." As a result, the statute's definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id*. at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).[21] Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Id*. at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

> if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id*.

Previously, I had interpreted this cited language to establish a two-step analytical process. First, I had to determine whether: a) the preponderance of the chest x-rays established the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy or autopsy evidence or other diagnostic results existed which were equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities exist in chest x-rays or their equivalent is demonstrated by autopsy/biopsy evidence or other means. Thus, as observed by the *Scarbro* court, at this stage of the analysis, definitive evidence indicating the large opacities are not really present would preclude invocation of the 20 C.F.R. § 718.304 presumption. Second, if the preponderance of the evidence demonstrates the existence of the requisite large opacities, I then consider all other relevant evidence to determine whether that

[20]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes, identified by letters. Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

[21]See also 20 C.F.R. §§ 718.304 (b) and (c).

evidence affirmatively shows the large opacities are not what they seem to be (complicated pneumoconiosis) due to some other pathology.

However, recently, the Benefits Review Board ("BRB" or "Board") rebuked my interpretation of *Scarbro.* Referencing a 1993 case from the U.S. Court of Appeals for the Fourth Circuit, *Lester v. Director, OWCP,* 993 F.2d 1143, 1145-46 (4th Cir. 1993), the Board mandated that in determining whether the regulatory presumption of complicated pneumoconiosis was invoked I "must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis." *Mullins v. Plowboy Coal Company,* No. 04-0716 BLA, Unpublished, July 8, 2005.

In light of the Board's instructions, I revert to an analysis of complicated pneumoconiosis in which all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co*., 176 F.3d 382 (6th Cir. 1999), *Melnick v. Consolidation Coal Co.,* 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985). Therefore, even after the presence of large opacities has been established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and represent complicated pneumoconiosis. For example, the Benefits Review Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in conjunction with CT-scan findings to determine there was sufficient evidence to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). And, in another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, my present adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a three step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if radiographic, biopsy or other equivalent evidence of large opacities exists, I must evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

1. Existence of Large Opacities

In the absence of biopsy evidence or other medical tests, Mr. Jordan must rely on chest x-ray imaging to establish the presence of large opacities. In the September 1, 2003 chest x-ray, Dr. DePonte observed a Category A large opacity. When Dr. Abrahams reviewed the same film, he noted an unspecified nodular infiltrate. Since Dr. Abrahams failed to specify the dimensions of the nodular patch, and considering Dr. DePonte's superior credentials, I find Dr. DePonte's assessment more probative and conclude that the September 1, 2003 establishes the presence of a large opacity.

In the October 23, 2003, Dr. Patel measured the pulmonary nodule as 0.8 centimeters. Dr. Scatarige believed the lesion was no greater than 1 centimeter. Since neither interpretation indicates the presence of an opacity greater than one centimeter, the October 23, 2003 film is negative for a large opacity.

Though Dr. Halbert did not find any large opacity consistent with pneumoconiosis in the February 19, 2004 chest x-ray, he noted nodular infiltrate in the right upper lobe without providing any measurement. Absent any dimension description, Dr. Halbert's interpretation is inconclusive as to whether the nodular image in the right upper lobe represents a large opacity.

When Dr. Patel and Dr. Scatarige reviewed the April 19, 2004 chest x-ray, they both found pulmonary masses greater than one centimeter. As a result, the April 19, 2004 is positive for a large pulmonary opacity.

Finally, while Dr. Wheeler observed "small" nodules in the right upper lung in the August 11, 2004 chest x-ray, he did not provide any dimensions nor define the term "small." In the absence of further specificity, I consider Dr. Wheeler's assessment to inconclusive on the presence of a large opacity

In summary, after setting aside the two inconclusive images from February 19, 2004 and August 11, 2004, the preponderance of the radiographic evidence consisting of the September 1, 2003 and April 19, 2004 chest x-rays establishes the presence of a large pulmonary opacity and outweighs the one negative film of October 23, 2003.

2. Other Evidence of Large Opacities

Since no other medical studies or tests which might identify large opacities, such CT scans or biopsy reports, have not been introduced into the record, I find no probative medical evidence exists to contradict the radiographic determination of large pulmonary opacities.

3. Cause, or Etiology, of Large Opacities

Through the preponderance of radiographic evidence, and in the absence of contrary evidence, Mr. Jordan has proven the existence of large opacities in his lungs. As a result, I move to the third adjudicative step and must consider other relevant medical evidence on the cause of the opacities prior to making a determination of whether Mr. Jordan has invoked the 20 C.F.R. §

718.304 presumption for complicated pneumoconiosis. At this point, I consider all other medical evidence to determine whether the large pulmonary opacities are due to coal dust exposure or coal workers' pneumoconiosis. In Mr. Jordan's case, this "other" medical evidence has three components: physician x-ray comments, pulmonary tests, and medical opinion based on evaluation and treatment.

X-Ray Comments

Notably, while disagreeing on the dimensions, all the physicians who reviewed Mr. Jordan's chest x-rays observed a nodular formation in the right upper lung and expressed an opinion on its origin. Dr. DePonte indicated the opacity was consistent with pneumoconiosis but could also be carcinoma. Dr. Abrahams stated the etiology was unknown. Dr. Patel first attributed the mass to granuloma or developing neoplasm. After reviewing a second chest x-ray, Dr Patel stated the cause of the mass was "indeterminate." He believed the opacity was either complicated pneumoconiosis or a malignancy. Dr. Scatarige did not find the mass to be consistent with pneumoconiosis. Instead, he attributed the opacity to infiltrate or scarring. Dr. Halbert did not believe the nodular infiltrate represented pneumoconiosis. Finally, Dr. Wheeler did not believe the mass was associated with pneumoconiosis. In his opinion, the pulmonary opacity was granuloma rather than metastases.

Readily apparent from the above comments, most of the physicians and radiologists to review the radiographic evidence essentially did not really know what the right upper lobe mass might be. While Dr. DePonte and Dr. Patel believed the opacity may be consistent with complicated pneumoconiosis, they also presented equally viable alternative diagnoses of cancer or malignancy. Due to the equivocal nature of their assessments, their consensus has insufficient probative value to establish that the opacity is related to pneumoconiosis. Similarly, though seemingly convinced the opacity is not pneumoconiosis, Dr. Scatarige, Dr. Halbert, and Dr. Wheeler were not certain of the cause the large pulmonary mass. Their uncertainty also diminishes the probative value of their collective determination. Accordingly, due this dearth of definitive medical opinion on the cause of the mass, the physician x-ray comments fail to establish that the large opacity is associated with pneumoconiosis.

Pulmonary Tests

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[22] post[23]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[24] pre Post**	**Comments**
DX 14	October 23, 2003 Dr. Rasmussen	50 72″	4.24	5.48	91	77	No[25]	Normal
DX 15	February 2, 2004 Dr. Rosenberg	50 73″	3.72	4.66	110	80	No[26]	
CX 2	April 19, 2004 Dr. Rasmussen	51 73”	4.03 4.11	5.33 5.40		76 76	No[27]	Normal
EX 1	August 11, 2004 Dr. Castle	51 73″	3.57 3.68	4.52 4.68	120 --	79 79	No	Normal lung volume

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO² (rest) pCO² (exercise)**	**pO² (rest) pO² (exercise)**	**Qualified[28]**	**Comments**
DX 14	Oct. 23, 2004 Dr. Rasmussen	38 39	62 66	Yes[29] No[30]	Minimal to moderate hypoxemia; valid per Dr. Michos (DX 16)
DX 15	Feb. 19, 2004	40.4	66.0	No[31]	

[22]Test result before administration of a bronchodilator.

[23]Test result following administration of a bronchodilator.

[24]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[25]The qualifying FEV1 number is 2.38 for age 50 and 72″; the corresponding qualifying FVC and MVV values are 2.99 and 95, respectively.

[26]The qualifying FEV1 number is 2.44 for age 50 and 73″; the corresponding qualifying FVC and MVV values are 3.07 and 97, respectively.

[27]The qualifying FEV1 number is 2.42 for age 51 and 73″; the corresponding qualifying FVC and MVV values are 3.05 and 96, respectively.

[28]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO² level, the value of the coal miner's pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[29] For the pCO² of 38, the qualifying pO² is 62, or less.

[30] For the pCO² of 39, the qualifying pO² is 61, or less.

[31]For the pCO² of 40.4 , the qualifying pO² is 60, or less.

	Dr. Rosenberg	42.4	74.4	No[32]	
CX 2	Apr. 19, 2004 Dr. Rasmussen	36 37	73 64	No[33] No[34]	Normal Minimal hypoxemia
EX 1	Aug. 11, 2004 Dr. Castle	41.5	64.1	No[35]	Mild hypoxemia

As discussed later, two physicians, Dr. Rasmussen and Dr. Castle, referenced the nature and pattern of the above pulmonary function studies to determine whether Mr. Jordan had coal workers' pneumoconiosis. However, neither physician presented their analysis in terms of identifying the etiology of the large pulmonary mass in the right upper lungs. Additionally, the pulmonary studies, standing alone, only establish the effects of an impairment rather than its cause. As a result, neither the pulmonary function tests nor the arterial blood gas studies demonstrate that the large pulmonary mass is attributable to pneumoconiosis.

Medical Opinions

Dr. Donald. L. Rasmussen
(DX 14 and CX 2)

On October 23, 2003, Dr. Rasmussen, board certified in internal medicine, conducted an evaluation of Mr. Jordan's pulmonary condition. Mr. Jordan had a history of arthritis. He was hospitalized in 2003 when he had back surgery to repair a ruptured disc. He presented with complaints of sputum and productive cough, wheezing, shortness of breath and dyspnea for about 3-4 years, chest pain and orthopnea. He and his wife walk about ½ mile each day to keep fit. Mr. Jordan sleeps on two pillows. Claimant did not currently smoke at the time of the examination. However, he had smoked about one pack of cigarettes per day, off and on, between 1971 and 1978, about one-half pack of cigarettes per day from 1986 to 1991, and returned to cigarettes for several months in 2003 while struggling with back pain. Mr. Jordan worked in the coal mines for 28 years as a roof bolter, which Dr. Rasmussen opined involved heavy manual labor."

A physical exam revealed no wheezes or rales, and breath sounds that were "normal." The chest x-ray was positive for pneumoconiosis. Although the pulmonary function test was normal, the arterial blood gas study showed a minimum to moderate impairment in oxygen transfer. Based upon "29 years coal mine employment and x-ray evidence," Dr. Rasmussen diagnosed coal workers' pneumoconiosis, chronic bronchitis and noted a "right upper zone nodule - ?" This physician believed the etiology of the pneumoconiosis was coal dust exposure, and the etiology of the chronic bronchitis was a combination of coal dust exposure and cigarette smoking. The etiology of the suspected nodule was "undetermined." Dr. Rasmussen reported a

[32]For the pCO^2 of 42.4 , the qualifying pO^2 is 60, or less.

[33]For the pCO^2 of 36 , the qualifying pO^2 is 64, or less.

[34]For the pCO^2 of 37 , the qualifying pO^2 is 63, or less.

[35]For the pCO^2 of 41.5, the qualifying pO^2 is 60, or less.

"moderate" respiratory impairment that would prevent Mr. Jordan from performing very heavy labor. Dr. Rasmussen noted that Mr. Jordan has two risk factors: cigarettes and coal mine dust exposure. The latter appeared to be a rather significant contributing factor in view of the pattern of no ventilatory impairment yet significant gas exchange impairment. Finally, Dr. Rasmussen recommended the "abnormal density" in the right upper lung zone be further evaluated.

On April 19, 2004, Dr. Rasmussen conducted another pulmonary examination. Mr. Jordan presented with breathing problems for the last 4 or 5 years. He complained of shortness of breath with exertion, productive cough and wheezing. He slept with two pillows at night, but denied paroxysmal nocturnal dyspnea. He was told in 2000 that he had pneumoconiosis on the basis of an x-ray. Mr. Jordan had smoked from age 17 at the rate of one-half pack of cigarettes per day until he quit in March of 2003. Mr. Jordan stopped working in the coal mines after 28 years and 8 months and worked for 25 of those years as a roof bolter performing "heavy and some very heavy manual labor."

A physical chest exam was normal. The chest x-ray interpreted by Dr. Patel indicated pneumoconiosis p/t with a profusion of 1/1. Dr. Patel also noted a Category A large opacity on the right upper zone, with "malignancy not excluded" and recommended "further follow up." The ventilatory function tests were normal and resting blood gases were also normal. With exercise, Mr. Jordan developed "moderate to marked impairment" in oxygen transfer and he was at least minimally hypoxic. Considering Mr. Jordan's significant history of coal dust exposure and the medical data, Dr. Rasmussen concluded he has coal workers' pneumoconiosis. Additionally, although malignancy cannot be "excluded," Dr. Rasmussen opined that the large pulmonary opacity in the right upper lung was consistent with complicated pneumoconiosis. He stated, "it is medically reasonable to conclude the patient does have complicated pneumoconiosis, Category A, which arose as a consequence of his coal mine dust exposure." The two contributing risk factors leading to his impaired lung function were exposure to coal dust and his past cigarette smoking. Of the two pulmonary irritants, Dr. Rasmussen believed coal dust was the more significant factor since Mr. Jordon had diminished oxygen transfer capacity yet normal ventilatory function. Due to the pulmonary impairment, Mr. Jordan does not retain the pulmonary capacity to perform the heavy labor required in his last coal mine job.

Dr. David M. Rosenberg
(DX 15)

On February 19, 2004, Dr. Rosenberg, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation of Mr. Jordan and reviewed some of his medical records, which included the x-ray dated October 23, 2003, and all of the objective tests and observations contained in Dr. Rasmussen's October 2003 pulmonary evaluation. Mr. Jordan had surgery on his back in 2003, but otherwise, had an unremarkable medical history. The patient complained of shortness of breath and had some degree of it over the last 4 to 5 years. Climbing up 20 steps would cause the patient to be symptomatic. He had frequent coughing at night and slept on one pillow. He also had some "nonspecific" chest pain with coughing. Mr. Jordan reported to Dr. Rosenberg that he had stopped smoking in 2003, but had smoked for about 10 years, overall, from age 16 at a rate of less than one pack of cigarettes per day. Mr. Jordan worked in the underground coal mines for 28.8 years and was a roof bolter for a majority of this

time. As a roof bolter, he would be required to lift various timbers up to 25-30 feet, bundles of bolts weighing 40 pounds and boxes of glue weighing 40 pounds, for a distance of 5 to 10 feet. Mr. Jordan stopped mining coal after he injured his back at work. Dr. Rosenberg also reviewed Dr. Rasmussen's pulmonary examination report and the associated radiographic evidence including the report of a Category A opacity.

The physical examination of the chest showed that Mr. Jordan's lungs were clear. Pulmonary function tests revealed no obstruction or restriction with a normal diffusing capacity measurement. The chest x-ray interpretation by a B reader revealed no micronodules associated with past coal exposure. The arterial blood gas test showed that his oxygenation, while reduced at rest, improved with exercise. The physician opined that based on normal total lung capacity, clear lungs, and the chest x-ray, which did not show any micronodularity, Mr. Jordan does not have coal workers' pneumoconiosis. He also believed that Mr. Jordan could perform his previous coal mine job from a pulmonary standpoint or similarly arduous types of labor. Dr. Rosenberg indicated that Mr. Jordan's "mildly reduced" $_pO_2$ was probably related to "ventilation perfusion mismatch from micro-atelectasis." Dr. Rosenberg concluded Mr. Jordan does not have coal workers' pneumoconiosis or an associated impairment.

Dr. James R. Castle
(EX 1)

On August 11, 2004, Dr. James Castle, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation of Mr. Jordan. Mr. Jordan was having difficulty breathing over the last 4 or 5 years, could walk a few blocks on level ground and could climb a flight of steps before becoming short of breath. Claimant complained of coughing, some wheezing at night and tightness in his chest. Mr. Jordan still has pain in his back and uses a TENS unit. He sleeps on one pillow at night. Dr. Castle noted a smoking history that began when Mr. Jordan was about 17 years old and continued until the year 2003. The patient reported smoking a total of about 10 years since he had quit smoking several times throughout that period. Mr. Jordan worked in the underground coal mines for 28 years and 8 months, last working in December of 2002. For the last 25 years, he was a roof bolter and according to Mr. Jordan, "there was not a whole lot of heavy labor involved," but he was continuously exposed to dust at the face of the mine. In his last few years mining coal, Mr. Jordan worked as a general insider laborer.

A physical exam revealed normal and equal breath sounds. Dr. Castle relied on Mr. Wheeler's interpretation of the August 11, 2004 x-ray showing no evidence of pneumoconiosis. Pulmonary function test results were normal, with only a "mildly reduced" diffusing capacity. The arterial blood gas test that he conducted and the tests that Dr. Castle reviewed showed a "mild degree" of hypoxemia "on occasion," which this physician attributed to "ventilation/perfusion mismatching" and not to coal workers' pneumoconiosis. On the basis of his own examination, Dr. Castle opined that Mr. Jordan does not have coal workers' pneumoconiosis and only has mild hypoxemia attributable to "ventilation/perfusion mismatching."

In addition to his pulmonary examination, Dr. Castle also reviewed other x-rays, pulmonary test results, and examination reports, including Dr. Patel's radiographic finding of complicated pneumoconiosis and Dr. Rasmussen's evaluations. At the end of the review process, Dr. Castle remained convinced that Mr. Jordan was not totally disabled due to coal workers' pneumoconiosis. Mr. Jordan may be disabled because of orthopedic problems related to his back, but this condition is unrelated to the inhalation of coal dust.

In addition to noting that the preponderance of the radiographic evidence in the record was negative for pneumoconiosis, Dr. Castle observed that Dr. Wheeler found several nodules consistent with granulomas or neoplasm; whereas, Dr. Patel diagnosed the opacities as Category A complicated pneumoconiosis and Dr. Rasmussen appeared to concur with that diagnosis. Believing the preponderance of the radiographic interpretations indicated complicated pneumoconiosis was not present and stressing the need for further evaluation of the nodule in the right upper lope, Dr. Castle disagreed with the finding of complicated pneumoconiosis by Dr. Patel and Dr. Rasmussen.

Turning to the pulmonary test results, Dr. Castle highlighted the demonstrated variability in the arterial blood gas studies. According to Dr. Castle, when coal workers' pneumoconiosis adversely affects oxygenation of the blood, the impairment is "persistent and constant" because black lung disease is an "irreversible condition." Consequently, since Mr. Jordan's arterial blood gas test results varied, his pulmonary condition was not caused by pneumoconiosis.

Discussion

Since Dr. Rosenberg did not specifically address the etiology of the right upper lung mass, his medical report has little probative weight on the issue of complicated pneumoconiosis.

At the time of the first pulmonary examination of Mr. Jordan, Dr. Rasmussen concluded that the etiology of the right upper lung mass was questionable and undetermined. Due to the uncertainty as to the cause of the mass, Dr. Rasmussen recommended further evaluation. When Dr. Rasmussen again examined Mr. Jordan several months later, no additional diagnostic tests of the mass had been conducted. Nevertheless, Dr. Rasmussen specifically diagnosed complicated pneumoconiosis. He concluded that though a malignancy could not be excluded, the large pulmonary opacity was consistent with complicated pneumoconiosis.

In contrast, when Dr. Castle reviewed the same radiographic studies, he disagreed with Dr. Rasmussen's diagnosis of complicated pneumoconiosis. In light of this medical dispute, I must assess the respective probative value of each medical opinion in terms of documentation and reasoning.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present

a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With those principles in mind, I give diminished probative value to Dr. Rasmussen's opinion on the issue of complicated pneumoconiosis because his assessment is inconsistent with the underlying radiographic evidence upon which he relied. Dr. Rasmussen did not interpret the April 19, 2004 chest x-ray associated with Mr. Jordan's pulmonary evaluation. Instead, he referenced Dr. Patel's interpretation. Significantly, as previously discussed, Dr. Patel did not reach a definitive diagnosis of complicated pneumoconiosis. To the contrary, Dr. Patel was clearly uncertain about the cause of the large pulmonary opacity. While he referenced Dr. Patel's alternative etiology finding of malignancy, Dr. Rasmussen did not indicate how he concluded a diagnosis of complicated pneumoconiosis was more accurate than a finding of malignancy.

In terms of documentary foundation, Dr. Castle's certainty that the mass is not complicated pneumoconiosis likewise has diminished probative value. Essentially, Dr. Castle based a definitive conclusion on radiographic reports which were equivocal rather than certain on the cause of the pulmonary opacity.

In light of the above determination, the medical opinion in this case is insufficient to establish that the large pulmonary opacity in the right upper lung is due to pneumoconiosis or Mr. Jordan's exposure to coal dust.

Conclusion

The preponderance of the probative radiographic studies establishes the presence of a large opacity in Mr. Jordan's right upper lobe. However, none of the radiologists who evaluated the opacity were able to identify the cause of the mass in the absence of further testing. Further, the other pulmonary testing was inconclusive Finally, although Dr. Rasmussen and Dr. Castle reached definitive, though contrary, opinions on the mass' origin, both physicians based their certain diagnoses on uncertain radiographic evidence. Upon consideration of the entire record, I find the medical evidence is insufficient to establish that the large pulmonary opacity is related to pneumoconiosis. Accordingly, Mr. Jordan is not able to establish the presence of pneumoconiosis through the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R.§ 718.304.

Medical Opinion

Although Mr. Jordan can not establish the presence of pneumoconiosis through chest x-ray evidence or regulatory presumption, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion.

During the course of two pulmonary examinations, Dr. Rasmussen diagnosed both clinical and legal pneumoconiosis. First, specifically citing the positive chest x-ray interpretation and Mr. Jordan's history of coal mine employment, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Second, noting Mr. Jordan's two pulmonary risk factors of cigarette smoke and coal mine dust, Dr. Rasmussen attributed Mr. Jordan's chronic bronchitis and pulmonary impairment to both irritants. Since the arterial blood gas studies showed diminished oxygen transfer while the pulmonary function tests were normal, Dr. Rasmussen also opined that coal dust was the more significant cause of the impairment.

Following his examination of Mr. Jordan and upon review of Dr. Rasmussen's reports, Dr. Rosenberg reached a different conclusion. Based on normal or near normal radiographic and pulmonary studies, and stressing an improvement in oxygen transfer capability upon exercise, he concluded that Mr. Jordan did not have pneumoconiosis.

For similar reasons, Dr. Castle also concluded Mr. Jordan did not have pneumoconiosis. He also stressed that due to the variability in the arterial blood gas studies, pneumoconiosis was not the cause of Mr. Jordan's breathing issue since black lung disease is a permanent and constant lung condition.

In assessing the respective probative value of these conflicting opinions, I first give Dr. Rasmussen's finding of clinical pneumoconiosis diminished probative value because it rested principally on his belief that the chest x-ray evidence was positive for pneumoconiosis, which is contrary to my determination that the preponderance of the radiographic evidence is negative for pneumoconiosis.

On the other hand, Dr. Rasmussen's finding of legal pneumoconiosis is better documented since it rests on all the results of two pulmonary examinations. Additionally, Dr. Rasmussen presented a reasoned explanation for his determination that coal dust rather than cigarette smoke was the predominant cause of Mr. Jordan's disabling pulmonary impairment.

Similarly, Dr. Rosenberg and Dr. Castle presented well documented medical opinions. They also presented well reasoned explanations for concluding that Mr. Jordan does not have pneumoconiosis. Their consensus represents the preponderance of the medical opinion in this case.[36] Additionally, considering their three respective explanations, I find Dr. Castle's

[36]I also note that Dr. Rosenberg and Dr. Castle are additionally specifically board certified in pulmonary disease; whereas Dr. Rasmussen does not have that specialty. Based on their superior credentials, Drs. Rosenberg and Castle are better qualified as pulmonary specialists and, therefore, deserve greater deference on the issue of whether Mr.

elimination of pneumoconiosis as a cause of Mr. Jordan's breathing difficulties based on the variable nature of the arterial blood gas studies to be the most probative since it is both consistent with all medical evidence in the record and the nature of pneumoconiosis.

In summary, Dr. Rasmussen's diagnosis of clinical pneumoconiosis has insufficient probative weight due to an incorrect documentary foundation. Further, the most probative opinion of Dr. Castle and Dr. Rosenberg's assessment represent the preponderance of the medical opinion and outweigh Dr. Rasmussen's diagnosis of legal pneumoconiosis. As a result, the preponderance of the probative medical opinion does not establish the presence of either legal or clinical pneumoconiosis. Accordingly, I find Mr. Jordan is not able to establish the presence of pneumoconiosis through medical opinion under 20 C.F.R. § 718.202 (a) (4).

Compton Consideration

As previously noted, the U.S. Court of Appeals for the Fourth Circuit requires consideration of the evidence together in the determination of whether pneumoconiosis is present. Since the preponderance of the radiographic evidence is negative for pneumoconiosis, the medical evidence does not support invocation of the regulatory presumption of complicated pneumoconiosis and the preponderance of the medical opinion does not support a finding of pneumoconiosis, consideration of the evidentiary record as a whole also fails to establish that Mr. Jordan has pneumoconiosis.

CONCLUSION

The preponderance of the radiographic evidence does not establish the presence of pneumoconiosis. Despite the presence of a large pulmonary opacity, the medical evidence is insufficient to establish that the mass is related to pneumoconiosis. Finally, the preponderance of the probative medical opinion fails to establish the presence of coal workers' pneumoconiosis in Mr. Jordan's lungs. As a result, Mr. Jordan has failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, and his claim for disability benefits under the Act must be denied.[37]

Jordan suffers from legal pneumoconiosis. *See Scott v. Mason Coal Co.,* 14 BLR 1-37 (1990) (en banc recon.); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

[37]Since Mr. Jordan has been unable to prove the first required element of entitlement, I need not address the remaining three issues.

ORDER

The claim of MR. FREDDIE R. JORDAN for benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: October 12, 2005
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).